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17. An EPSDT visit is paid a flat rate for the visit, and if the following are performed, reimbursement is made over and above the visit rate:

- urine test,
- hematocrit or hemoglobin,
- TB test,
- hearing test using a pure tone audiometer,
- developmental test,
- immunizations (Reimbursement is for administration if the vaccine is part of the vaccine replacement program. If the provider does not participate in the vaccine replacement program, or the vaccine is not part of the vaccine replacement program, reimbursement is made for the acquisition as well as for administration.)

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EPSDT is paid on a weekly cycle through the Invoice Processing system using established HCPCS codes and the normal Medicaid methods.

Whenever an EPSDT component that has a HCPCS code is provided outside of an EPSDT package, it is billed under regular Medicaid. An example would be if the only service provided to a child is a developmental test, it is billed separately to Medicaid because there is no method for tracking the child to assure that the rest of the components are performed.

07-01-94

EPSDT visit rates are set under Individual Practitioner Services for given HCPCS codes (See Attachment 4.19-B, Page 1, 1).

In consultation with providers of in-home blood lead investigations, we obtained costs and established an average to be used as the rate for the initial and follow-up epidemiological investigations. The in-home educational visit rate is the same as for a home health nurse visit.

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The following services are not normally covered under the State Plan, but will be covered if the Medical Services Administration consultant agrees with the provider that the service is medically necessary. Reimbursement will be as follows:

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17. Cont'd.

Christian Science nursing services - The hourly nursing services as for private duty nursing will be used.

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Private duty nursing services - The rates established for the hourly nursing component of the Children's Special Health Care Services Specialized Home Care Program (administered by the Michigan Department of Public Health) and the Home and Community Based Services Waiver II (administered by the Michigan Department of Mental Health) will be used.

Screening and preventive services - Reimbursement is governed by the applicable category of the specific service.

Reimbursement for EPSDT support services will be on a fee-for-service basis, within Medicaid established frequency limits, to agencies that have been certified by the Michigan Department of Public Health as qualified to provide these services. Payment will be the lesser of the charge or fee screens established by the department. Fee screens are established relative to home health services and other similar services reimbursed by the department.

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18. Indian Health Centers (IHC) Services

If eligible, a Tribal 638 facility may choose to participate in the Medicaid Program and receive reimbursement for Medicaid covered services under one of three options. However, the Indian Health Center may be only one type of provider and receive only one reimbursement rate that applies to all clients.

Option 1

As a provider of fee-for-service for non-enrolled Qualified Health Plan (QHP) enrollees, the Indian Health Center may receive reimbursement as established in the State Plan's Attachment 4.19-B, Page 1, Item 1. In addition, the Indian Health Center is free to negotiate contracts with the Qualified Health Plan and receive reimbursement at the contracted rate for QHP enrollees. The negotiated rate may or may not be the IHS rate. There is no state full-cost reimbursement under this option, regardless of the rate tribal centers negotiate with QHPs.

Option 2

As a provider of Federally Qualified Health Center services, the Indian Health Center may receive reimbursement as established in State Plan Attachment 4.19-B, Page 6c, Item 14.

Option 3

As a Tribal 638 facility, the Indian Health Center may, in accordance with the Federal Regulation notice on the IHS per visit outpatient rate, receive for non managed care enrollees, the IHS per visit outpatient rate for a face-to-face visit at the IHC.

A visit is a face-to-face contact within the IHC between a Medicaid beneficiary and the provider of health care services who exercises independent judgment in the provision of Medicaid covered services. All outpatient ancillary Medicaid services are bundled in the per visit rate and cannot be billed as a separate visit. The IHC provider may be credited with no more than one face-to-face visit with a given beneficiary per day, except when the beneficiary, after the first visit, suffers illness or injury requiring additional diagnosis or treatment.

The Indian Health Center is free to negotiate contracts with the Qualified Health Plans and receive reimbursement at the contracted rate for QHP enrollees. The negotiated rate may or may not be the IHS rate. There is no state full-cost reimbursement under this option, regardless of the rate tribal centers negotiate with QHPs.

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The IHS per visit outpatient rate will be determined by the Indian Health Service in accordance with the annual Federal Register notice. No annual reconciliation will be performed.

Under all 3 options described above, it is the tribal facility's responsibility to pursue reimbursement from all legally liable third parties, including Medicare, prior to seeking payment for services from Medicaid.

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19. Dental Services

The Michigan Medicaid Program has two separate methods of reimbursement dependant upon the Medicaid recipient's county of residence.

For services reimbursed under the fee for service methodology as administered by the Michigan Department of Community Health, providers are reimbursed the lesser of the Medicaid fee screen or the provider's usual and customary charge minus any third party payment. A provider's usual and customary charge should be the fee they most frequently charge their patients with regard to special considerations or financial status.

For recipient's under 21 years of age residing in selected counties, dental services are reimbursed by a fiscal intermediary. Reimbursement for these services is the lesser of the:

a) fee submitted for the procedure;

b) fee the dentist has filed with the intermediary in advance; or,

c) customary fee, which is equivalent to the 80th percentile of fees submitted by participating dentists.

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COORDINATION OF TITLE XIX WITH PART B OF TITLE XVIII

Except for a nominal recipient copayment (as specified in Attachment 4.18 of this State Plan), if applicable, the Medicaid agency uses the following general method for payment:

XX 1. Payments are limited to State plan rates and payment methodologies for the groups and payments listed below and designated with the letters "SP."

For specific Medicare services that are not otherwise covered by this State Plan, the Medicaid agency uses Medicare payment rates unless a special rate or method is set out on Page 3 in Item ____ of this attachment (see 3 below).

____ 2. Payments are up to the full amount of the Medicare rate for the groups and payments listed below, and designated with the letters "MR."

____ 3. Payments are up the amount of a special rate, or according to a special method, described on Page 3 in item ____ of this attachment, for those groups and payments listed below and designated with the letters "NR."

____ 4. Any exceptions to the general methods used for a particular group or payment are specified on Page 3 in item ____ of this attachment (see 3 above).

QMBs:	Part A SP Deductibles	SP Coinsurance
	Part B SP Deductibles	SP Coinsurance
Other Medicaid Recipients:	Part A SP Deductibles	SP Coinsurance
	Part B SP Deductibles	SP Coinsurance
Dual Eligibles (QMB) Plus):	Part A SP Deductibles	SP Coinsurance
	Part B SP Deductibles	SP Coinsurance

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

Payment of Medicare Part A and Part B Deductible/Coinsurance

QMBs:	Part A	SP Deductibles	SP	Coinsurance
	Part B	SP Deductibles	SP	Coinsurance
Other Medicaid Recipients	Part A	SP Deductibles	SP	Coinsurance
	Part B	SP Deductibles	SP	Coinsurance
Dual Eligible (QMB Plus)	Part A	SP Deductibles	SP	Coinsurance
	Part B	SP Deductibles	SP	Coinsurance

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Payment of Medicare Part A and Part B Deductible/Coinsurance